

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-08-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The therapeutic exercises, manual therapy technique, ultrasound, addition to short and long opponens-adjustable M. P. flexion control, repair of orthotic device-labor component per 15 min., addition to short and long opponens-thumb abduction ("C") bar, unlisted modality, occupational therapy re-evaluation from 6-1-04 through 6-28-04 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-26-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Neither the requestor nor the respondent provided EOB's for CPT codes 97110, 97140 and 97035 on 6-22-04 and 6-24-04. There is no "convincing evidence of the carrier's receipt of the provider request for an EOB" according to 133.307 (e)(2)(B). **No reimbursement recommended.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 6-1-04 through 6-28-04 as outlined above in this dispute.

This Decision and Order is hereby issued this 17th day of February 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

January 20, 2005

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-05-1092-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: IRO 5055

Dear Ms. ____:

IRI has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of Independent Review, Inc. and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a licensed physical and occupational therapist and is currently on the TWCC Approved Doctor List.

Sincerely,

Gilbert Prud'homme
Secretary & General Counsel
GP:thh

REVIEWER'S REPORT

M5-05-1092-01

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor:

- Correspondence
- Physical therapy reports 05/26/04 – 06/28/04

Information provided by Respondent:

- Designated doctor review

Information provided by Treating Doctor:

- Office notes 12/29/03 – 07/29/04
- FCE 07/13/04
- Radiology report 12/29/03

Information provided by Orthopedic Surgeon:

- Office notes 12/29/03 – 08/30/04
- Operative report 12/30/03

Information provided by 2nd Orthopedic Surgeon:

- Office note 04/26/04

Clinical History:

This claimant suffered an injury to his left index finger in a work-related accident on _____. He suffered a proximal phalanx fracture and was repaired with an open reduction internal fixation.

Disputed Services:

Therapeutic exercises, manual therapy technique, ultrasound, addition to short & long opponens-adjustable M.P. flexion control, repair of orthotic device-labor component per 15 min, addition to short & long opponens-thumb abduction ("C") bar, unlisted modality, occupational therapy re-evaluation during the period of 06/01/04 thru 06/28/04

Decision:

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

Rationale:

1. Dr. Panday and the certified hand therapist documented objective deficits in range of motion, strength, and function.
2. Dr. Panday and the certified hand therapist recommended conservative non-surgical intervention.
3. The claimant was not functioning at full duty.
4. Frequent objective re-evaluations were performed by the certified hand therapist.
5. Flow sheets documented appropriate treatment interventions and were oriented towards return to work goals.
6. Objective improvements were recorded, including functional gain.
7. The therapy received was delivered in an efficient manner requiring only 4 visits of hand therapy.